THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-2079.M5

MDR Tracking Number: M5-04-2662-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 4-23-04.

The IRO reviewed myofascial release, therapeutic exercises, group therapy, office visits, joint mobilization, muscle testing (97750-MT), record copies, range of motion (95851), supplies/materials, and medical conference from 4-30-03 to 8-11-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 7-23-04, the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
4-30-03	97250	$43.00	$43.00	F	$43.00	NA	Per EOB dated 6-18-03, this service was paid ; therefore, no dispute exists.
5-23-03	99080-73	$15.00	$0.00	F	$15.00	Rule 129.5	The carrier's denial states the TWCC-73 was not properly completed or was submitted in excess of the filing requirements. Review of the form indicates it was properly completed. Recommend reimbursement of $15.00
7-8-03	99080-73	$15.00	$0.00	V	$15.00		Per Rule, the TWCC-73 is a required report and not subject to an IRO review. Recommend reimbursement of $15.00.
5-23-03	97750-MT	$172.00	$0.00	G	$43.00 per body area	1996 MFG, Med GR I E 3	The carrier did not indicate what muscle testing is global to. Global fee concept only applies to surgery. Per Medicine GR, reimbursement shall be per body area. Records indicate two body areas were tested. Recommend reimbursement of $43.00 x 2 = $86.00.
6-20-03 7-1-03	97265	$43.00 x 2	$0.00	No EOB	$43.00	1996 MFG, Medicine GR	Neither party submitted an EOB; therefore this service will be reviewed per the MFG. Since the carrier did not provide a valid basis for the denial, recommend

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
							reimbursement of $43.00 x 2 = $86.00
8-26-03	99213	$58.99	$40.79	F	$47.20 x 125% = $59.00	Rule 134.202(b)	Per Trailblazer Fee Schedule, recommend additional reimbursement of $18.21.
TOTAL							The requestor is entitled to fee reimbursement of $220.21

The above Findings and Decision are hereby issued this 8th day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 4-30-03 through 8-26-03 in this dispute.

This Order is hereby issued this 8th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

June 29, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2662-01
TWCC#:
Injured Employee:
DOI:
IRO Certificate No.: 5055

Dear Ms. ___:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: correspondence, H&P, office notes, physical therapy notes, ROM reports and radiology reports.

Clinical History:
The records indicate the patient was injured on the job on ___. He continued to work and reported the incident of his injury on ___. On ___, he referred himself for medical care. X-rays were taken. Medication was prescribed as well as physical therapy prescribed. He continued to experience ongoing problems and requested a TWCC #53, change of treating doctors. He sought care in a new doctor's office on April 28, 2003.

Disputed Services:
Myofascial release, therapeutic exercises, group therapy, level III & IV office visits, joint mobilization, muscle testing, record copies, ROM measurements, supplies & materials and medical conference during the period of 04/30/03 through 08/11/03.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

Rationale:
A thorough evaluation was performed on this patient and appropriate documentation was provided. At that time, an appropriate treatment program was begun. In addition, diagnostic testing confirmed this patient's injuries as well as assisted the doctor in formulating the treatment plan that was ordered.

National Treatment Guidelines allow for the treatment of this type of injury. There is sufficient documentation to clinically justify all denied services in this case. In conclusion, all of the denied services during the period of 4/30/03 through 8/11/03 were, in fact, reasonable, usual, customary and medically necessary for the treatment of this patient's on the job injury.